Employment Development Department
State of California

# WORK SHARING (WS)
# UNEMPLOYMENT INSURANCE PLAN APPLICATION

1. Enter the following information as shown on the most recent DE 3DP/DE 9423, Quarterly Returns:

   Employer Name: _____ Telephone Number: (_____) _____

   Mailing Address: _____

   California Employer Account Number (Eight Digits ): _____ _____ _____ - _____ _____ _____ _____ - _____

2. Enter specific type of business:

   _____

3. Enter the employer name that will be used on WS Certifications:

   _____

4. Location(s) where WS will occur, if different from Section 1:

   Employer Name: _____ Employer Name: _____

   Address: _____ Address: _____

   Telephone Number: (_____) _____ Telephone Number: (_____) _____

5. Is your business/organization a public entity? ❑ Yes ❑ No

   If Yes, enter an "X" in the box next to the type of public entity that best describes your organization:

   ❑ City ❑ County ❑ State ❑ Federal ❑ School District ❑ Other (Specify) _____

6. Enter effective date of WS plan (New or Renewal):

   _____/ _____/ _____

   Note: The earliest effective date for a *new* WS plan is the Sunday prior to the "first contact date" shown below in the EDD USE ONLY box. The effective date for a *renewed* WS plan is the day after the prior plan expires, providing the plan application is submitted no more than 10 days after the prior plan has expired.

   A. If you are renewing your plan, how many additional WS Certifications, DE 4581WS, do you need?

   _____

7. If you are adding employee(s) or work unit(s) to your existing plan, enter the effective date of the expanded coverage.

   _____/ _____/ _____

   Note: The effective date is the Sunday prior to the date the expanded coverage will occur.

**FOR EDD USE ONLY**

First Contact Date _____/ _____/ _____ EFF. Date _____/ _____/ _____

❑ New WS Plan ❑ Renewal ❑ Expanded WS Coverage

WS ee: _____ %: _____ SIC: _____ Union (Y or N) _____ Status (T or P) _____

8. Enter the estimated weekly percentage reduction in hours and wages of employees participating in the WS plan:

_____ %

9. Please fill in the blanks (use additional paper if necessary):

| A. Work Unit(s) participating in WS | B. Number of employees in unit(s) | C. Number of employees participating in WS |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| TOTALS: | | |

10. Please enter an "X" in the box next to the appropriate response:

A. Payroll periods are: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Other (Specify)_____

B. If pay periods are weekly or bi-weekly, the payroll ending day is:

❑ Mon ❑ Tues ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun

11. Is this WS plan part of a transition to a permanent layoff or closure?

❑ Yes ❑ No

12. Briefly describe the circumstances requiring your use of the WS program to avoid layoffs:

_____

13. Are any participating employees covered by a union/collective bargaining agreement?

❑ Yes ❑ No (If Yes, page 4 must be completed)

14. Your participation in the Work Sharing program is confidential. Occasionally the Employment Development Department receives requests for the names of companies that would be willing to share their experiences in this program. Are you willing to have your name released for this purpose?

❑ Yes ❑ No

15. Please answer the following:

Does your WS plan involve:

| | | |
|---|---|---|
| A. At least two employees? | ❑ **Yes** | ❑ **No** |
| B. At least 10% of your workforce or work unit(s)? | ❑ **Yes** | ❑ **No** |
| C. At least a 10% reduction in BOTH hours worked and wages? | ❑ **Yes** | ❑ **No** |

***THANK YOU FOR CHOOSING WORK SHARING!***

## CERTIFYING INFORMATION

1. We understand that if we are a participating employer using the tax rate method, our reserve account will be charged in the usual manner for benefits paid under this program. In addition, these charges may increase the employer's unemployment insurance contribution rate in future years.
2. We understand that if you are a participating reimbursable employer, we will be billed quarterly for the cost of benefits paid in the same manner as they are currently billed for other unemployment insurance benefits.
3. We understand that a holiday cannot be used as a Work Sharing day unless the employee(s), in the same position, performed compensated services as part of the employee(s) normal weekly hours of work on that holiday, during the twelve month period prior to the employer's participation in the Work Sharing program. Furthermore, we understand that we are not to issue certification forms to employees that contain a holiday as the only Work Sharing day. (Section 1279.5 of the California Unemployment Insurance Code).
4. We will provide the Employment Development Department with the weekly percent of reduction in hours and wages for each participating employee as a result of this Work Sharing program.
5. We understand that in order to be eligible, any employee must have worked at least one normal work week with no reductions prior to issuance of certification forms for benefit payment.
6. We understand that if any employee is working for a school district and/or non-profit entity providing services to a school district, we must provide the Employment Development Department with the dates individual employees are between successive academic terms and/or in a recess period. Furthermore, we understand that we are not to issue certification forms to employees for those weeks the employee is between successive terms or in a recess period, where there is reasonable assurance that the employee will return to work. (Section 1253.3 of the California Unemployment Insurance Code).
7. We understand that a plan approved by the Employment Development Department shall expire six months after its effective date. Expanded coverage approved to add other work unit(s) shall expire on the same date as the plan. A new plan may be approved immediately following the expiration of the previous plan if the employer submits the new plan prior to the expiration of the previous plan and the employer finds it necessary to provide employees with continuous coverage under this program.

We have provided the information on this form so that our employees may participate in the Work Sharing Unemployment Insurance program, in lieu of layoffs. We understand that failure to provide correct information, in accordance with this certification and in accordance with the provisions of the California Unemployment Insurance Code, could result in a denial or cancellation of this plan.

Employer Signature: _____ Date: ____/____/____

**Private Business:** Is the signature above of a corporate officer, sole proprietor or general partner? ❑ Yes ❑ No
If No is checked, this WS Plan Application will be returned for the appropriate signature.

**Public Entity:** Is the signature above of an executive officer or person with authorization, substantiated in writing, to sign?

❑ Yes ❑ No

If No is checked, this WS Plan Application will be returned for the appropriate signature.

***Please print or type the following information:***

Name of person signing above: _____ Position or Title: _____

Contact Person: _____ Telephone Number: (____) _____

## IF THERE IS A UNION/COLLECTIVE BARGAINING AGREEMENT PAGE FOUR MUST BE COMPLETED

## UNION/COLLECTIVE BARGAINING UNIT(S) CONCURRENCE

This page may be duplicated if additional signatures are required

The authorized union representatives certify that they have read and understand the "Certifying Information" on page three and agree that their membership may participate in the WS program.

| | |
|---|---|
| *Please print or type the following information*<br>Union Name: _____<br>Union Local Number: _____<br>Telephone Number: (_____) _____<br>_____<br>Name of Authorized Union Representative<br>_____<br>Position Title<br>_____<br>Authorized Union Representative Signature<br>Date: _____/ _____/ _____ | *Please print or type the following information*<br>Union Name: _____<br>Union Local Number: _____<br>Telephone Number: (_____) _____<br>_____<br>Name of Authorized Union Representative<br>_____<br>Position Title<br>_____<br>Authorized Union Representative Signature<br>Date: _____/ _____/ _____ |

| | |
|---|---|
| *Please print or type the following information*<br>Union Name: _____<br>Union Local Number: _____<br>Telephone Number: (_____) _____<br>_____<br>Name of Authorized Union Representative<br>_____<br>Position Title<br>_____<br>Authorized Union Representative Signature<br>Date: _____/ _____/ _____ | *Please print or type the following information*<br>Union Name: _____<br>Union Local Number: _____<br>Telephone Number: (_____) _____<br>_____<br>Name of Authorized Union Representative<br>_____<br>Position Title<br>_____<br>Authorized Union Representative Signature<br>Date: _____/ _____/ _____ |

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| **Return this application to:**<br><br>Employment Development Department<br>Special Claims Office<br>P. O. Box 269058<br>Sacramento, CA 95826-9058 | To order Work Sharing Certifications, DE 4581WS, call: (916) 464-3323<br><br>For further information, call the Special Claims Office at: (916) 464-3343 or FAX (916) 464-3342 |